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Education and debate

Ethical debate

Too drunk to care?

What should doctors do if they are faced with a medical emergency after they have had a few alcoholic drinks? Dr David Cressey describes how, although not entirely sober, he felt compelled to help an unconscious person at a sports event, and two medical ethicists, a psychologist, and another doctor give their views.

Ethanol, emergencies, and ethical dilemmas

David M Cressey

While attending a recent sports event as a spectator, I was faced with a dilemma. I saw an incident in which a spectator was left unconscious and could have injured his neck. The injured man had been placed in the recovery position but was not moving. As the official crowd doctor was not immediately on hand, I felt I should at least offer my services. However, I had had an alcoholic drink. I told the attending ground steward that I was an anaesthetist, and warned him of the risks of a possible neck injury. The steward then asked for my help. I quickly assessed the patient; he had a clear airway, was breathing adequately, had a strong pulse, was pink and well perfused. None the less he had a coma score of 3, and I had seen him drinking and eating moments before the accident.

When the paramedics and official crowd doctor arrived, the patient was fitted with a hard collar and was placed on a scoop stretcher. Having introduced myself to the crowd doctor and briefed him on the patient's state, I told him that I had had a drink. I then had to decide whether I should participate further in the patient's care. Here was a young man with a possible neck injury and in a hard collar. He had a full stomach, a coma score of 3, and although currently maintaining his own airway, the protective reflexes were obtunded.

Immediate intubation had been considered but deferred. If intubation became essential it could well have proved technically demanding. While acknowledging the quality of training and skills in airway management of paramedical and medical staff from other specialties, my contribution as an experienced anaesthetic specialist registrar with daily practice of intubation could have proved crucial here. I therefore chose to accompany the patient and the crowd doctor in the ambulance on the grounds that if the young man failed to maintain his airway during transit I could assist. In fact, the transfer was uneventful and the patient was beginning to wake on arrival at the hospital.

The problem

The question remains: at what level of intoxication do doctors become too drunk to care for a patient? Under their terms of service (paragraph 4), general practitioners are obliged to give treatment needed immediately because of an emergency at any place in their practice area when they are asked to do so. Caveats attached to this include the fact that they must be available and be physically capable of attending the emergency.

For doctors attending victims of mishaps that are neither part of their professional remit nor part of their terms of service, the case is rather different. There does not seem to be any legal requirement for a doctor to assist in an emergency where no duty of care or professional relationship exist between the victim and the doctor. However, the General Medical Council, in its booklet *Good Medical Practice*, states that: "In an emergency, you must offer *anyone* at risk the treatment you could reasonably be expected to provide." It seems therefore that even if doctors have no legal obligation

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Should a doctor who has been drinking alcohol offer assistance when the official doctor is not available?

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to assist in an emergency, they have an ethical one. Indeed, does failure to help in an emergency leave the doctor open to allegations of professional misconduct?

A matter of degree

In an emergency, when no alternative help is available, it seems clear that aid should be given. When it becomes a matter of the degree of experience of the carer versus clarity of judgment, it is no longer black

and white. What effect does drinking alcohol have on the “treatment you could reasonably be expected to provide”? If you have taken any alcohol at all, should you refrain from offering help if alternative trained assistance is available, regardless of your relevant specialist skills? When does it become more appropriate for a less experienced but perhaps more mentally alert carer to be responsible for a patient? What are the legal implications if you assist and something goes wrong? When are you too drunk to care?

Commentary: Guidelines could never be developed

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Part of our work is to encourage doctors to reflect on their actions and to adhere to morally appropriate rules of conduct. However, not everything can or should be codified. We expect off duty doctors to act as good—or decent—Samaritans when they are confronted with someone needing medical help. It would be too much to expect them to be flawless in that capacity or to programme their private actions so that the benefit-risk ratio for those who might need their services would always be optimal.

Dr Cressey’s dilemma is not as special as it seems on first sight. True, alcohol may impair mental functions, but it is not unique in that respect. Dr Cressey might just as easily have been affected by a 20 hour shift at work or a baby son who had kept him awake all night. The real issue is that there is something special about alcohol. Doctors may feel embarrassed for having drunk alcohol, even if this was done in moderation and when off duty.

To act or not to act

Dr Cressey’s case was not extreme. There was a fellow doctor on hand, who was made an accomplice—so to speak—in the moral dilemma, and who took the decision for Cressey to go ahead. Take a more exceptional case. Imagine you are an obstetrician, the only person on a plane with (para)medical training, and you have been drinking champagne. A steward calls for help as a woman is giving birth. She or her child is sure to die if not given proper attention. Do you offer your assistance? It is clear that you are qualified, but the alcohol may have affected your competence.

On the other hand, a clumsy lay person might put them in greater jeopardy. To act or not to act, that is the question in medicine.

Make the decision even more difficult. It is not a life or death situation as the woman may be able to hold on until landing; or she is unconscious and not able to give informed consent. You are an orthopaedic surgeon and you smoked cannabis before boarding. No guideline could deal with all these variations. You must make up your own mind, however clouded it is.

Even if we wanted to draw up a guideline on alcohol use, it would be virtually impossible. Because of individual differences in sensitivity, there is no clear cut relation between the concentration of alcohol in the blood and mental performance. Moreover, the minimum concentration would have to be related to the complexity of the medical skills required and also to the risk and the severity of the possible consequences of acting or not acting.

However, there is also a legal side—doctors may be sued for making the wrong choices. We do not welcome this development, which might prompt doctors to save their own skin at the expense of people needing treatment. We prefer to look at physicians as good Samaritans rather than as liability risks.

A few rules of thumb may be offered to doctors. If you have drunk alcohol, ask a sober qualified colleague to treat the patient. If such a colleague is not at hand, treat patients who would be at risk of dying if treatment is withheld. Do not overestimate your skills—your judgment may be impaired. Therefore, ask bystanders, if present, for feedback on your behaviour.

Commentary: Balance the risk as best you can

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You are at a dinner party. You are a pathologist who last had skill training in resuscitation 30 years ago. A businessman in his 60s develops chest pain and collapses. He stops breathing and you are unable to feel his pulse or hear a heartbeat. None of the other guests knows what to do. Because you have had several drinks you become concerned about the advisability of further involvement and decide against trying external

cardiac massage and mouth to mouth ventilation. Everyone else would feel that your decision was illogical and preposterous.

In other circumstances what is right may be much less clear. There are no easy answers to Dr Cressey’s questions. At a certain level of alcohol intake, a given doctor’s performance will deteriorate to a point where the risk-benefit ratio from a particular intervention in a

particular emergency becomes unfavourable. Influencing factors include the amount of alcohol drunk, tolerance to it, the clinical problem, the nature of any appropriate intervention, the doctor's relevant expertise, the availability and nature of alternative assistance, and the risk attached to doing nothing. One potential difficulty is that although doctors are theoretically best placed to evaluate the various factors, their judgment may be impaired.

No easy answers

Dr Cressey's expertise could have been life saving. In most situations where doctors are confronted with an emergency outside hospital, whether or not they have been drinking, appropriate and better care from paramedical staff and other doctors is already present or imminent. However, situations similar to that described by Dr Cressey occur from time to time.

For most doctors a single drink is unlikely to impair judgment and performance to an extent that would justify withholding a clinically important intervention. At this level of consumption most doctors are allowed

by law to drive at 70 miles per hour. While the potential for dilemma will usually arise at higher levels, many patients have doubtless had cause to be grateful for the ministrations of doctors who would have failed breathalyser testing.

Act in good faith

Many hospital patients have doubtless had cause to be grateful to junior doctors who have been busy on call for such long periods that they would be unsafe to drive. Doctors who have had more than one or two drinks and find themselves unexpectedly in a "clinical" situation must make every effort to recognise the potential for misjudgment and to guard against inappropriate enthusiasm for intervention. They should evaluate the relative risks from intervention and non-intervention. Occasionally, well meaning doctors will get it wrong. However, it is rightly expected that doctors should behave intelligently and responsibly and act in good faith whenever there is such a call on their services.

Commentary: Doctors can never have a moral holiday

Pat Walsh

From a moral point of view, Dr Cressey acted properly, and probably wisely, in informing others that he had been drinking. He thus shared responsibility with them for any decision taken. Indeed, one might take this as evidence that he was not, in that nicely ambiguous phrase, "too drunk to care." Several interesting moral issues are raised by circumstances in which doctors who are not entirely sober find themselves unexpectedly called on to act. But perhaps the question at the heart of Dr Cressey's unease is this one: could the scope of the moral duty of care be such that no doctor should ever be less than totally sober? Or, to put it another way, are doctors ever morally off duty?

Ideal versus ordinary standards

Perhaps none of us is entitled to a moral holiday, in the sense that we can ever justifiably claim there are circumstances in which no moral demand can rightly be made of us. In moral theory it is usual to distinguish two levels of moral standards—the ordinary and the ideal. Ordinary moral standards are the minimal standards for moral decency that are required of everyone. Ideal moral standards, however, may be regarded as aspirational in character, and, because they express the individual's personal sense of obligation, are not to be expected of everyone.

The person who acts in accordance with some ideal typically acts in a way that goes beyond the demands of duty. It is argued by some that these so called supererogatory actions are wrongly conceived as such because our best is what is morally required of us at every moment. Nevertheless, most of us acknowledge

the possibility of heroic actions which, perhaps regrettably, are not to be expected of the majority.

No need for moral heroes

Dr Cressey's worry, however, is not about whether doctors must be moral heroes. He asks whether the ordinary moral standards required of doctors preclude social drinking. It does seem that some people have a more demanding moral minimum than others, largely because of a role they have voluntarily assumed. Doctors, teachers, and parents are paradigm examples of this. But while teachers are allowed to go off duty, morally speaking, at the end of the working day, parents and doctors cannot. However, even parents can take time off as long as they have made adequate provision for the care of their offspring.

It seems that doctors can never renounce their duty to assist should the need arise, and therefore that they are never morally off duty in this sense. On the other hand, while we can ask of doctors what we ask of all people in positions of responsibility for others—that they are not drunk on the job—it is unfair to expect doctors never to drink socially just in case a medical emergency should arise. In fact, I do not think this is required. If society were to demand that doctors hold themselves in a constant state of preparedness to provide an optimal level of care, we would also require of them the sort of lifestyle that would ensure peak physical and mental fitness. And, perhaps more tellingly, we would not impose on them the sort of working hours and conditions that lead to errors of judgment caused, not by alcohol perhaps, but by exhaustion.

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Adjuvant tamoxifen: how long before we know how long?

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Despite recent advances, we still need more information from large clinical trials to define the optimum duration of tamoxifen treatment after surgery for breast cancer. Tamoxifen is the most widely prescribed and arguably the most important anticancer drug in clinical use. It has been established beyond doubt that adjuvant tamoxifen after primary treatment for early breast cancer improves survival.^{1,2} Tamoxifen also reduces the incidence of second primary breast cancers,^{1,2} preserves bone mineral density,³ and may lower the incidence of coronary heart disease.⁴ Although tamoxifen is generally well tolerated, it can produce menopausal symptoms and, on occasion, it has serious side effects, including an increased risk of endometrial carcinoma.^{1,2} However, the benefits of a few years of adjuvant tamoxifen treatment clearly outweigh the risks, and its widespread adoption is considered the major contributor to the recent fall in mortality from breast cancer in the United Kingdom.⁵

Evidence on duration

For how long should adjuvant treatment with tamoxifen be continued? Controversy remains. Recent reports from randomised studies comparing different treatment periods favour longer courses, but we are still far from defining an optimum. We do know from the preliminary findings of three European studies, in which more than 10 000 patients participated, that continuing treatment beyond two to three years reduces the risk of cancer recurrence by about a quarter.⁶⁻⁸ Longer follow up in these studies is required to establish whether survival is also improved.

Treatment beyond five years has not been adequately studied. None of the three studies (total 1700 patients) comparing adjuvant tamoxifen for five years with longer treatment have found a noticeable difference in survival—and they report conflicting results on recurrence. The National Surgical Adjuvant Breast Project (NSABP) B-14 study reported that survival free of disease was worse in patients treated for 10 years than in those treated for five years.⁹ A similar study from the Eastern Cooperative Oncology Group reported an opposite trend with fewer recurrences in those treated for longer than five years.¹⁰ However, a Scottish trial reported no appreciable differences in recurrence.¹¹

Explaining inconsistency

These statistically inconsistent and puzzling results may be explained partly by the early closure of the NSABP study by its data monitoring committee. Based on the study's findings, a clinical announcement was issued by the National Cancer Institute recommending five years' adjuvant treatment as standard in breast cancer that had not spread to the lymph nodes.¹² This recommendation, made before the European Cooperative Oncology Group's data became available, has been criticised as premature since it was based on a comparatively small number of individual events.¹³ Although 1000 women participated in NSABP B-14,

Summary points

Tamoxifen is the most widely prescribed anticancer agent; used as adjuvant therapy it is a major contributor to the recent decline in breast cancer mortality

Controversy remains over how long tamoxifen treatment should be continued

Continuing treatment beyond two to three years reduces the risk of recurrence, which may result in improved survival

Treatment beyond five years has not been adequately studied; there are conflicting results from three small studies

Large scale recruitment into ongoing studies is needed to resolve the uncertainty over the balance of benefits and risks of long term adjuvant tamoxifen

only those with a good prognosis (no spread of cancer to the lymph nodes) were included, so the total number of adverse events was comparatively low.

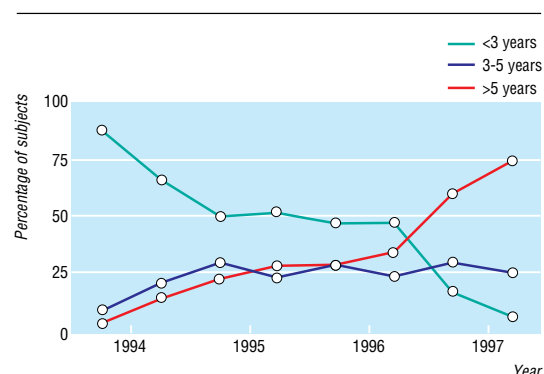
There is further concern that follow up in all of these trials is not yet sufficiently long for any potential late benefits from prolonged tamoxifen treatment to register. The worldwide overview of adjuvant tamoxifen studies showed that benefit persisted for several years after the tamoxifen treatment had been stopped.² Thus, delayed effects may have an important bearing on the eventual interpretation of these trials. Although further analysis of these trials is expected early in the next millennium, it is unlikely that this will produce definitive conclusions.

Need for reliable assessment

With an estimated one million women taking tamoxifen as adjuvant treatment, even small benefits would translate into many thousands of lives saved. The risks and benefits must be defined as accurately and as soon as possible. Even if new hormonal approaches eventually supersede tamoxifen, a reliable assessment of the optimal duration of tamoxifen treatment is relevant. At present, all we can really say with confidence is that two years' adjuvant tamoxifen treatment is less effective at preventing recurrence than five years' treatment. Further trials of tamoxifen duration are therefore appropriate and necessary.

Major trials, definitive answers

Two major trials—aTTom (adjuvant tamoxifen treatment offers more?) in the United Kingdom and ATLAS (adjuvant tamoxifen longer against shorter)



Duration of treatment with tamoxifen before patients were randomised into the aTTom trial

internationally—are currently aiming to recruit at least 20 000 women in order to answer definitively the question on duration of adjuvant tamoxifen. These parallel trials are designed pragmatically with randomisation at the point when “substantial uncertainty” arises as to whether to stop or continue tamoxifen treatment. At this point women who give informed consent are randomised to stop or continue adjuvant tamoxifen for at least five more years. The trials are therefore able to accommodate divergent and evolving clinical opinion. Indeed recruitment into these trials has shown that the point at which doctors become uncertain about continuing treatment has shifted appreciably—from around two years towards five years—undoubtedly in response to publication of the recent European studies (figure).

Trial entry

All doctors treating breast cancer patients should be aware of the uncertainty over how long adjuvant tamoxifen should be prescribed for. This now includes general practitioners since patients are often still taking tamoxifen when they are discharged from hospital follow up. When in doubt about stopping treatment,

entry into a tamoxifen duration trial through a participating local breast unit should be considered. Only through widespread support for these studies can we resolve the complex balance of benefits and risks of long term adjuvant tamoxifen treatment.

Information about aTTom and ATLAS is obtainable from the aTTom Study Office, CRC Trials Unit, The Medical School, Birmingham, B15 2TA or ATLAS Study Office, CTSU, Radcliffe Infirmary, Oxford, OX2 6HE.

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- 1 Early Breast Cancer Trialists Collaborative Group. Systemic treatment of early breast cancer by hormonal, cytotoxic or immune therapy. 133 randomised trials involving 31,000 recurrences and 24,000 deaths among 75,000 women. *Lancet* 1992;339:1-15, 71-85.
- 2 Early Breast Cancer Trialists Collaborative Group. Tamoxifen for early breast cancer: an overview of the randomised trials. *Lancet* (in press).
- 3 Love RR, Mazess RB, Tormey DC, Harden HS, Newcomb PA, Jordan VC. Bone mineral density in women with breast cancer treated for at least two years with tamoxifen. *Breast Cancer Res Treat* 1988;12:297-302.
- 4 McDonald CC, Stewart HJ. Fatal myocardial infarction in the Scottish adjuvant tamoxifen trial. *BMJ* 1991;303: 435-7.
- 5 Beral V, Hermon C, Reeves G, Peto R. Sudden fall in breast cancer death rates in England and Wales. *Lancet* 1995;345:1642-3.
- 6 Current Trials Working Party of the Cancer Research Campaign Breast Cancer Trials Group. Preliminary results from the cancer research campaign trial evaluating tamoxifen duration in women aged fifty years or older with breast cancer. *J Natl Cancer Inst* 1996;88: 1834-9.
- 7 Swedish Breast Cancer Cooperative Group. Randomised trial of two versus five years of adjuvant tamoxifen for postmenopausal early stage breast cancer. Swedish Breast Cancer Cooperative Group. *J Natl Cancer Inst* 1996;88:1543-9.
- 8 Delozier T, Spielmann M, Macé-Lesec'h J, Janvier M, Lubinski M, Asselain B, et al. Short term versus lifelong adjuvant tamoxifen in early breast cancer (EBC): a randomised trial (TAM-01) [abstract]. *Proc Am Soc Clin Oncol* 1997;16:128.
- 9 Fisher B, Dignam J, Bryant J, DeCillis A, Wickerham D, Wolmark N, et al. Five versus more than five years of tamoxifen therapy for breast cancer patients with negative lymph nodes and estrogen receptor-positive tumours. *J Natl Cancer Inst* 1996;88:1529-42.
- 10 Tormey D, Gray R, Falkson H for the Eastern Cooperative Oncology Group. Post chemotherapy adjuvant tamoxifen therapy beyond five years in patients with lymph node-positive breast cancer. *J Natl Cancer Inst* 1996;88:1828-33.
- 11 Stewart HJ, Forrest AP, Everington D, McDonald CC, Dewar J, Hawkins R. Randomised comparison of 5 years of adjuvant tamoxifen with continuous therapy for operable breast cancer. The Scottish Cancer Trials Breast Group. *Br J Cancer* 1996;74:297-9.
- 12 National Cancer Institute. *Adjuvant therapy of breast cancer: tamoxifen update*. Bethesda, MA: National Institutes of Health, 1995. (Clinical announcement)
- 13 Peto R. Five years of tamoxifen—or more? *J Natl Cancer Inst* 1996;88:1791-3.

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BMJ data

Letters p 1537

As well as giving our usual audit data on decision and publication times, we provide here data on the *BMJ*'s impact factor since 1990, accesses to our web site (www.bmj.com), and data on submissions and acceptances for both articles and letters, over the past five years.

Time to decision and publication

We aim to make a decision on publication within eight weeks (56 days); to reject papers unsuitable for external peer review within two weeks (14 days); and to publish a paper within eight weeks of acceptance. The table below gives data on our performance in the second half of last year, together with previous years' performance since we started recording it in 1993.

Overall our performance on decision times improved in the second half of last year, while that on publication times deteriorated—largely owing to our having accepted more articles than usual in nearly all sections. Between July and December we made a decision within 56 days for 85% of all papers submitted (1762/20 260) and for 59% of those accepted (103/174). We accepted 70% within 66 days, and the

mean time to accept a paper was 54 days. We met our target of rejecting papers without peer review within 14 days for 61% of papers (846/1396); 86% were rejected within 24 days.

Overall we published only 19% within eight weeks of acceptance, 24% within 10 weeks, and 32% within 12 weeks. Of full research papers, however, we published 24% within eight weeks, 30% within 10 weeks, and 44% within 12 weeks.

Table 1 *BMJ* impact factor 1990-7

Year	1990	1991	1992	1993	1994	1995	1996	1997
Impact factor	3.29	3.76	3.87	4.34	4.50	4.41	4.55	4.95

Table 2 Web accesses to www.bmj.com: number of separate hosts served

	1996 (21-27 Dec)	1997 (21-27 Dec)	1998 (17-23 Apr)*
Hosts served	5762	10 608	20 015

*After relaunch of *BMJ* site with full text.

Table 3 Number of submissions of articles to *BMJ* 1993-7 and acceptance rates from different parts of the world 1993-7

	1993		1994		1995		1996		1997
	No submitted	% Accepted	No submitted	% Accepted	No submitted	% Accepted	No submitted	% Accepted	No submitted
Total	4690	18	4495	16	4572	17	4637	18	4732
Europe:									
UK	3454	20	3225	18	3153	19	3130	20	3065
Non-UK	702	12	727	9	839	12	881	13	1015
North America	134	19	153	19	186	22	186	20	242
South and Central America	9	44	10	0	13	31	12	8	18
Australasia	182	18	145	17	147	18	147	19	150
Africa	39	13	37	16	29	24	41	24	52
Middle East	68	12	66	5	64	12	63	10	61
Asia	102	13	132	5	141	7	177	5	129

Table 4 Number of letters submitted to *BMJ* and proportion accepted by region, 1993-7

Region	1993		1994		1995		1996		1997	
	No submitted	% Accepted	No submitted	% Accepted	No submitted	% Accepted	No submitted	% Accepted	No submitted	% Accepted
United Kingdom	3448	46	3227	45	3698	38	3306	39	3146	36
Rest of Europe	236	43	261	46	214	36	191	34	251	33
North America	121	40	123	46	112	41	103	47	125	31
Africa	33	27	27	30	15	47	23	22	34	35
Middle East	22	27	28	36	31	16	16	19	24	8
Asia	64	23	42	26	70	20	61	30	74	26
Australasia	95	28	97	49	78	40	66	41	76	42
Central and South America	8	25	12	17	10	0	4	0	11	55
Total	4027	45	3817	45	4230	38	3770	38	3741	35

Table 5 Results of *BMJ* audits. Values are percentages unless stated otherwise

Audit	Decision within 56 days		Accepted papers		Rejected papers (no peer review)		Publication after acceptance within:		
	All papers	Accepted papers	Decision within 66 days	Mean time to decision (days)	Decision within 24 days	Mean time to decision (days)	8 weeks	10 weeks	12 weeks
1993:									
Jan-June	88	73	85	41	76	19	38	75	95
July-Dec	86	62	75	50	84	18	27	66	85
1994:									
Jan-June	88	64	76	48	84	18	13	24	57
July-Dec	83	64	73	51	73	21	40	67	87
1995:									
Jan-June	72	41	53	69	56	26	38	60	76
July-Dec	73	34	43	81	65	22	32	50	73
1996:									
Jan-June	81	43	59	59	65	24	19	35	53
July-Dec	76	53	56	88	62	23	29	52	66
1997:									
Jan-June	68	35	45	81	72	20	24	42	61
July-Dec	85	59	70	54	86	15	19	24	32

One hundred years ago The depopulation of France

The late Professor Tarnier, according to Dr Dureau, was the first private person who offered a reward to increasers of the population. He instituted a prize of 100 francs for each child that might be born in the year after its institution, namely, 1892, in his native village, Arc-sur-Tille, Burgundy. Dr Cabanès, however, has found that a similar prize had already been offered for the same year by the Comte de Chardonnet, Mayor of Charette. It appears that not a single child was born in the village of Charette in 1891. The noble Mayor announced by beat of the drum in the market place that "We, Mayor of Charette, promise to award a prize of

one hundred francs to every woman who brings a viable child into the world in the course of the year 1892. The said reward will be delivered at the end of the week following the declaration of the birth of the child at the Town Clerk's office. The parents must be inhabitants of the commune of at least one year's standing and the child must be born in wedlock." Nobody can deny the advisability of these qualifications, but it seems strange that the necessity for increase of population is so keenly felt in France that a mayor should think it right to deliver such a proclamation. (*BMJ* 1898;i:170)

Coping with loss

Facing loss

Colin Murray Parkes

To conclude this series, I examine some of the problems that explain why the care that is needed in situations of bereavement and loss may not be provided, and I suggest some solutions.

Why losses may go unrecognised

Although the death of a spouse or child is a public event that seldom goes unrecognised, many other types of loss do not attract attention or support to those who suffer them. This has been called disenfranchised grief.¹ It is not unusual for more than one of the reasons listed in the box to apply.

People with unrecognised losses are of particular importance to members of the healthcare professions for three reasons: their physical and mental health may be at risk; they seldom come to the notice of the usual caring agencies; and we often find out about them because of our access to confidential information that is hidden from others. In fact we may be the only people who are in a position to help.

Hidden losses

Hidden losses arise when a relationship has been kept secret, when the ending of the relationship cannot be acknowledged, or when the loss is associated with feelings of shame or inadequacy. If the bereaved person has had a homosexual relationship that has been concealed, the death of the partner may be a great cause for grief that the survivor may not feel free to express or share. Often the relationship has been known or guessed at by others who colluded by pretending that the relationship did not exist. The loss is not admitted to by anyone: the bereaved try hard to hide any expression of grief for fear that their secret will be discovered, and others are debarred from expressing sympathy or support.

There is a lot of truth in the saying "To understand is to forgive," and this applies to the patient as well as the doctor. People with secrets are often trying to hide



ADRIANA DORSETT

Summary points

Losses may go unrecognised because they are concealed or avoided by those who experience them, misrepresented by caregivers, or take place very gradually

Losses are often concealed or misrepresented out of kindness, but the supposed harmful consequences of revealing the truth rarely match the harmful consequences of concealment

Men, military personnel, members of emergency services, and doctors are often expected to inhibit grief. They are also likely to find it difficult to ask for help

Even mothers who have planned for and eagerly anticipated the birth of a child may need to grieve for the many losses that result from it

The most important thing that members of the healthcare team have to offer to those who are afraid is a relationship of trust and respect, from which they can explore the situation they face, share the feelings that arise, and review the implications of loss

from themselves—"If I don't tell anyone about it I won't have to think about it and can pretend that it is not true." Like most forms of denial this device is seldom successful because we have to be on our guard against the danger that we are trying to avoid. Once the secret has been shared we no longer need to be on our guard against it.

Trust has to be earned: we have no right to expect our patients to trust us and often have to address this problem before attempting to deal more directly with the secrets. By reassuring patients that anything they tell us will be treated as confidential and putting our case notes aside when confidential issues are touched on, we show sensitivity and earn trust. In the end, however, it is likely to be non-verbal messages—the welcoming smile, a hand on the shoulder at the right moment, a flash of eye contact when some particularly dangerous topic has been touched on—that indicate our trustworthiness.

Problems of this kind are particularly common among people with HIV infection and other diseases that may be sexually transmitted. They are also common consequences of mental illnesses, which may be aggravated as a result of these problems.

Members of the healthcare team often have confidential information that may make us the only people who can give support to patients with such diseases. Some patients will shut themselves up at home,

This is the last in a series of 10 articles dealing with the different types of loss that doctors will meet in their practice

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Why loss may go unrecognised

- Hidden losses associated with shame or stigma (for example, HIV infection or mental illness)
- Concealment or misrepresentation of losses by caregivers, as when caregivers conceal information from children or elderly people
- Gradual losses, as when the imperceptible progression of an illness is ignored (for example, in infertility or Alzheimer's disease)
- Avoided grief, as when people deny their need to grieve for social or other reasons (for example, in "macho" men after any loss or in mothers who have mixed feelings on the birth of a baby)

refuse necessary treatments, and resist attempts at rehabilitation. By criticising or browbeating them we only increase their feelings of insecurity and fear. By treating them with respect, withholding judgment, and encouraging them to believe in themselves, we stand a much better chance of helping.

Members of the healthcare professions may be the only people in a position to help people with unrecognised losses

Concealment or misrepresentation of losses by caregivers

Losses are often concealed or misrepresented out of kindness. A mother may not tell her young son that his father is dying because she wants to protect him from the pain that he will experience if he learns the truth. A nurse in a residential home for the elderly may not invite residents to attend the funeral of another resident because she thinks it will upset them. A doctor may give quite unjustified reassurance to a patient with

heart disease for fear that the truth will cause the patient to drop dead.

In an important recent study, 50 people with learning disorders who were being cared for in the community and who had recently lost a parent were compared with 50 others who had not been bereaved.² Those who had been bereaved were unlikely to have been warned of the coming death of their parent and to have been taken to visit the grave, and only half were known to have attended the funeral. They had much higher scores on measures of anxiety, depression, hyperactivity, stereotyped movements, and other indicators of distress. Despite this, most of the professional and family carers who looked after them were quite unaware of their distress and inclined to attribute their symptoms to brain damage rather than to bereavement and its secondary consequences.

Concealment of a loss often leads to bad consequences: the loss may eventually become obvious and the deception may be seen through; inaccurate information may leave the recipient ill prepared to deal with subsequent events; and an opportunity to help someone to cope with reality may have been missed. The supposed harmful consequences of revealing the truth rarely match the harmful consequences of concealment.

Gradual losses

When a loss is very gradual or imperceptible, or the person has been born with a disfigurement or disability of which they only gradually become aware, they often succeed in ignoring or minimising the implications of the loss. So too do their family, friends, and caregivers, who may not understand that depression or other psychological symptoms are often indications that the person is becoming aware of the loss and that the time has come for someone to acknowledge the need to grieve and to support them through their grief.

Assumptions about loss and principles of care**Assumptions**

Grief is an important experience that needs to be acknowledged

Losses that have been anticipated and prepared for are much less likely to give rise to later psychiatric and other problems than losses that are unexpected

Many of the losses that are met with in medicine affect the lives of members of the families of our patients

Grieving people tend to oscillate between avoiding and confronting grief; problems arise when either of these ways of coping predominates

Anger and shame can complicate the course of grief

The minority who are at special risk (people with traumatic losses, personal vulnerability and lack of social support) can be identified before or at the time of a loss

Losses can affect the carer as well as the cared for; doctors are not immune to grief

Principles

Members of the caring professions have many opportunities to do this

By sensitively imparting information and support we can help people to prepare for the losses that are to come

It is the family, which includes the patient, that is the unit of care

Some people need permission and encouragement to grieve and reassurance of the normality of grieving. People may also need permission and reassurance that they do not have to grieve all of the time; they may need opportunities and encouragement to re-plan their lives in a way that values the past

We need to reserve judgment and show understanding

Members of the caring professions are well placed to assess risk, to give support, and advise those who need additional help how to get it

We need to become aware of our own reactions to our patients and their illnesses, and to acknowledge and seek to meet our needs for support

The supposed harmful consequences of revealing the truth rarely match the harmful consequences of concealment

Infertility

The infertile couple often deny for many years that they will never succeed in conceiving. As Bryan and Higgins put it, "Some secretly carry on hoping against all odds, if only to postpone the inevitable pain and misery of giving up hope."³ They may not realise that their increasing irritability, their resentment of people who have had an abortion, and their loss of sexual libido are all symptoms of grief. When, eventually, they do acknowledge the true situation, each partner will grieve in an individual way and this may make it hard for them to support each other. Each may blame the other, for infertility is always assumed to be somebody's "fault." Not only is infertility inconspicuous, it is also something about which people often feel ashamed. Infertile couples often keep their sadness to themselves and social support from friends and family is lacking. Those unable to conceive may feel jealous of those who can and friends with children may not like to draw attention to their good fortune by sympathising.

Each partner in an infertile couple will grieve in an individual way, and this may make it hard for them to support each other

Alzheimer's disease

Wives and husbands of people with Alzheimer's disease may be reluctant to acknowledge that they no longer recognise the person they married. Both social pressures from their families and allegiance to the spouse force them to pretend that the gross change in personality that has resulted from the disease has not impaired their relationship. Sadly, the failure to acknowledge the truth may cause them to blame the spouse for failing to be the sensitive, intelligent person he or she always was. Support and understanding may be needed if the wife or husband is to grieve for this very real loss and find a way of living with and supporting the different spouse whom they now have. When eventually the spouse dies, relief may make it hard to grieve at a time when everyone seems to expect it.

In these cases the understanding and support of members of the healthcare team can facilitate grieving, mitigate the feelings of anger and guilt that are inevitably present, and point the person towards the help of others who have experienced similar difficulties—through, for example, Issue (formerly the National Association for the Childless) and the Alzheimer's Disease Society.

Avoidance of grief

Although most people oscillate between confronting and avoiding grief, extreme avoidance of grief always takes place for a reason. People may avoid grief because they are members of a family or a society in which grief is frowned on; they may avoid it because they fear the consequences if they should express it; or

they may simply believe that they have more important things to do.

Cultural influences may determine when and how grief is expressed, and anthropologists have reported great variation from one society to another.⁴ Whether or not the societal inhibition of grief within a culture is harmful is a matter for debate and research. One thing seems clear, however.

The wife or husband of someone with Alzheimer's disease may need support and understanding if they are to grieve for the loss of the person they married

Even within cultures there is great variation. Men, in particular, are often expected to inhibit their grief. This may explain the finding that, whereas women usually show more overt distress in the first year of bereavement than men and are more likely to seek psychiatric help, men take longer to return to the levels of adjustment of married controls than women.⁵ They are also more likely to die from heart disease after bereavement than are women of the same age.⁶ It seems that it is the inhibition of grief that is damaging to the heart rather than its expression. Bereaved men benefit more than women from therapies that encourage them to express feelings; bereaved women are more likely to benefit from help in reviewing and reshaping their assumptions about the world.⁷

Cultural pressures also prescribe when and whether grief is an appropriate response. Mothers who have babies are under considerable social pressure to rejoice rather than grieve. For many mothers to be, however, pregnancy is unwanted, and even those who have planned for and eagerly anticipated this event may need to grieve for the many losses that result from it. Kumar and Robson found that 10% of mothers had clinical levels of depression during pregnancy and 14% in the first three months thereafter.⁸ Similar figures have been reported in five other studies reviewed by Brockington.⁹

A mother may experience considerable shame if, because of feelings of depression, fear, or grief, she is lacking in maternal feelings for her new baby. She is likely to be acutely conscious of the danger that her lack of feeling constitutes to her child. If she finds the courage to admit this, we need to recognise the seriousness of the situation and to reassure her that it is not her fault. If we help her through the period of emotional turmoil, maternal feelings will usually emerge. If they do not the mother will need and should benefit from the help of a child psychologist.

Those who overreact to loss will benefit from opportunities to re-examine their negative assumptions about themselves and their world

Another group who tend to deny their own needs to grieve are members of the caring professions, particularly doctors, who spend their lives caring for others but who often find it difficult to acknowledge their own emotional needs. If we accept that it is appropriate and therapeutic for our patients and their

families to express grief, why should we deny ourselves that privilege? It would seem that, like soldiers and members of the emergency services, we are trained to remain calm in the face of danger. This leads us to the assumption that, even when the emergency is over, we have no need to get upset. Yet, as Bennet's paper in this series showed, such stoicism is bought at a cost and doctors who find ways to meet their own needs for emotional expression and support are likely become better doctors and to find greater satisfaction in their work.¹⁰

Chronic grief

Some people become stuck in states of chronic grief that cannot easily be put aside; this may result from high levels of anxiety about the world that now exists. Grief is both an expression of distress and a cry for help.

A woman who has had a bad experience of pregnancy may experience high levels of anxiety and a propensity to depression which may spoil her next pregnancy. Similarly people who have recovered from mental illness may dread its return. If they experience a loss that triggers natural feelings of grief they may convince themselves that they are "breaking down," and this may indeed increase the risk that they will.

Those who overreact to loss will benefit from opportunities to re-examine their negative assumptions about themselves and their world, to review and

replan their lives in ways that value and build on the past, and to venture forth into a world that seems more dangerous than it really is. Nothing succeeds like success, and quite small beginnings can lead to a restoration of confidence that eventually allows great progress to be achieved. There is much to be said for John Bowlby's claim that the most important thing that we have to offer frightened or grieving people is a "secure base," a relationship of respect—with a person who has the time, knowledge, and willingness to remain involved—that will last them through the bad times.¹¹

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- 1 Doka K, ed. *Disenfranchised grief*. Lexington, MA: Lexington Books, 1989.
- 2 Hollins S, Esterhuizen A. Bereavement and grief in adults with learning disabilities. *Br J Psychiatry* 1997;170:497-501.
- 3 Bryan E, Higgins R. *Infertility: new choices, new dilemmas*. Harmondsworth: Penguin, 1995.
- 4 Rosenblatt PC, Walsh RP, Jackson DA. *Grief and mourning in cross-cultural perspective*. Washington, DC: HRAF Press, 1976.
- 5 Parkes CM, Weiss RS. *Recovery from Bereavement*. New York: Basic Books, 1983.
- 6 Jacobs S. *Pathologic grief: maladaptation to loss*. Washington, DC: American Psychiatric Press, 1993.
- 7 Schut HAW, Stroebe M, van den Bout J, de Keijser J. Intervention for the bereaved: gender differences in the efficacy of two counselling programs. *Br J Clin Psychol* 1997;36:63-72.
- 8 Kumar R, Robson KM. A prospective study of emotional disorders in childbearing women. *Br J Psychiatry* 1984;144:35.
- 9 Brockington I. Puerperal mental illness. *Practical Reviews in Psychiatry* 1986;8:3-9, 9:1-8.
- 10 Bennet G. The doctor's losses. *BMJ* 1998;316:1238-40.
- 11 Bowlby J. *A secure base: clinical applications of attachment theory*. London: Routledge, 1988.

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Health needs assessment

Assessment in primary care: practical issues and possible approaches

John R Wilkinson, Scott A Murray

This is the fourth in a series of six articles describing approaches to and topics for health needs assessment, and how the results can be used effectively

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continued over

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This article is a practical guide to help primary care groups (as set out in the NHS white papers^{1 2}) and also individual practice teams assess the health needs of their respective populations before providing or commissioning services to meet these needs. Historically, much service provision has been service led rather than needs led, provided as before and at the convenience of providers rather than patients. The needs of patients are now accepted as being central to the NHS. An explicit framework is needed to help assess needs more systematically, to demystify the process, and to help prioritise and action changes.³ This paper outlines an approach that is feasible for individual practices, groups of practices, and populations of around 100 000 people (typically the size of the new primary care groups described in the white paper).

Do we get involved with wider health needs or just health service needs?

Health professionals understandably tend to think of health needs in terms of services they can provide. Patients may have different ideas about what affects

Summary points

A practical strategy for assessing local health needs is required

This approach uses practice held data, routinely available local statistics, a patient/public consultation exercise, and (possibly) a postal survey to gain various perspectives on need

Unless specific, useful summary data are obtained, details will obscure the larger picture

Stages in this strategy are to collate the information, assess priorities, and plan and evaluate changes

Time and resources must be available at practice and locality level, but many important health needs cannot be met by health services alone

their health. This might include getting a job, having a roof over their head, or having a bus route which makes getting to see the doctor easy. A group of practices may decide that they do not have the time and resources to consider these types of needs, and they may feel even less confident about being able to do anything about such needs. But if primary care has the aim of improving the health status of individuals as well as providing health services, such factors must at least be identified for action by someone else. Lalonde, when minister of health in Canada, emphasised the importance of lifestyles and the environment on health as well as the influences of human biology and health-care provision.⁴ Thus this paper embraces needs for health—needs for services and more general needs.

Levels, approaches, and methods

The process of health needs assessment can be carried out at different levels, from international down to individual patient. Different approaches can be used at each level (from global to specific diseases).

Levels

Needs assessment can be carried out at various levels:

- *International*—By the World Health Organisation, for example
- *National*—The advantage of tackling some national priorities locally (such as mental health) is that it may be easier for health authorities or boards to fund identified gaps in services. But remember that the most common complaints presented by patients—stress, arthritis, and dyspepsia—have never been identified as national priorities⁵
- *Regional*—the need for a liver transplantation service could be assessed at this level
- *Health authority or board level*—The needs for neonatal care, obstetric care, or dietetics may be assessed at this level
- *Locality*—The creation of primary care groups will lead to increasing importance for needs assessment to be undertaken at this level. Generally, larger populations will produce more robust results than single practices. There is also no need for every practice to carry out similar studies when it is unlikely that there will be different needs between practices. Issues suitable for tackling at this level might include unwanted pregnancy, dental caries, inequalities in service provision of community nursing
- *Practice specific*—It is worth thinking about a single piece of needs assessment work where a practice is relatively large and is situated in an area of particular need. Issues such as mental health and drug addiction may be particularly relevant
- *Small neighbourhood*—Some practices have a group of patients who live in a well defined disadvantaged area. Such an area can usefully be targeted
- *Individual*—used daily in consultations by general practitioners and nurses.

Approaches

When using a global approach, get an initial overview of the health and social needs of the population group, then identify which of a variety of interventions might best improve the health and wellbeing of patients. Issues relating to the wider determinants of health can

be taken to the relevant agencies for action (in London and in Edinburgh, bus routes have been changed and play areas developed).

A focused approach can centre on:

- A specialty (mental health, for example)
- A disease (epilepsy, Alzheimer's disease, cerebral palsy, or diabetes⁶)
- A client group (elderly people, single mothers, the unemployed, farmers)
- Groups waiting for interventions (people awaiting an operation or physiotherapy)
- Vulnerable groups of patients (ethnic minorities, etc)
- Patients who are socially deprived, to address issues of inequity.

Methods of assessing needs

Different information sources and methods of investigating give complementary insights into health needs generally.⁵ Practitioners should concentrate on gathering the information that will give them the most useful insights, rather than on collecting all sorts of information that might turn out to be useful. A locally appropriate mix of methods can use data from various sources: information held by the practice, computer records, and "soft" information from all members of primary healthcare teams. These sorts of data are good for assessing ongoing physical problems.

Local statistics are routinely available from health authorities or health boards, hospitals, and the census. Public consultation exercises, which can utilise focus groups, rapid appraisal, or other methods of interacting with local people, are good for uncovering problems relating to drug abuse, HIV, and social issues.

A postal survey may be worth considering to provide data about acute illness in the community and suggestions for changes to services. A covering letter by the patient's general practitioner may improve the return rate.

Detailed guidance on practical aspects is now available, including a workbook and a "really rough guide."⁷⁻¹¹

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Involving others

Most approaches can be undertaken by an individual or a group. Although group work is more difficult to organise, there are major benefits. Group members who work in the community, such as health visitors and district nurses, have valuable knowledge of local needs and will feel an ownership of the results if they have been involved. Practice staff involved may require additional resources or locum cover. Public health and primary care can contribute complementary skills and insights at every level.

Any practice or group of practices needs to decide how the public will be involved at an early stage. Methods for involving the public have been described by Mays et al.¹²

Consultants working in hospital or community trusts usually have a clear picture of the needs for their particular service. This can be a rich source of help, advice, and information. Combining specialist expertise and the experience of generalists can produce valuable information. Other service providers should also be considered, such as hospices and other agencies both in the statutory and voluntary sector.

Core practice data

- Age-sex profile in 5 year bands for male and female patients
- Prescribing details:
 - Repeat prescribing rates from practice computer
 - Collated prescribing figures (PACT or Scottish Prescribing Analysis)
- Prevalence of some specific chronic disease (for example, ischaemic heart disease, chronic obstructive airways disease, asthma, epilepsy, psychosis, thyroid disease, hypertension, diabetes)
- Data from practice's payment details:
 - Percentage of patients attracting deprivation payments
 - Family planning uptake
 - Temporary residents
 - Obstetric care and other item of service payments
- Health promotion and disease prevention data:
 - Smoking, alcohol consumption, substance misuse, body mass index
 - Immunisation coverage (2 and 5 year olds)
 - Cervical cytology coverage
- Contacts with general practitioners:
 - Surgery consultation rate per 1000 registered patients per year
 - House call rate per 1000
 - Out of hours visits per 1000
- Knowledge (mostly implicit) of local health needs:
 - Health visitor: practice profile, breast feeding rates, use of other agencies
 - District nurse: workload details, observations in patients' homes
 - Practice nurse: workload details (for example, influenza coverage rate)
 - Receptionists: patients' perceptions, availability of appointments
- Deaths—causes, place of death, preventable factors
- Turnover of patients
- Other sources—suggestions box, patient participation group
- Notes search may yield:
 - Incidence of acute illnesses and symptoms presenting
 - Telephone ownership (percentage)
 - Unemployment rate, domestic problems documented

If reliable data (on use of investigations, referrals, etc) are available from other sources, use these data rather than duplicate work in the practice for the following:

- Use of investigations (per 1000 patients per year, individually for microbiology, haematology, biochemistry, radiology, electrocardiography)
- Referrals to physiotherapy, chiropody, occupational therapy (per 1000 patients per year)

Depending on funding, some aspects of needs assessment may be carried out by an external agency if the relevant skills or time is not available (for example, to carry out focus groups or a postal survey).

Defining the problem or area to be assessed

Most practices and even locality groups will have little time to devote to needs assessment, and therefore it is important to target any effort in the most productive way. A first needs assessment project needs to deliver rapid success to stimulate those involved to progress further. In a few practices—perhaps in an area of inner city deprivation—the issues that need to be tackled will be very obvious, but for most practices the priorities will vary depending on the demographic profile, common illnesses, and social needs of the practice population. Consider the frequency, impact, and costs of different diseases. Priorities might be defined with the following questions:

- Is there a realistic chance of achieving change?
- Is the cost of undertaking the work proportional to the likely benefits?
- What are the priorities being suggested by other agencies—the health authority or health board, social services?
- Does the practice or primary care group wish to look at issues that are not directly under their control such as housing and transport?

Five stage approach

Stage 1: Collect routine practice information

Routine data from general practices can highlight needs that are dealt with in primary care. The box lists data that give an overall practice perspective on needs: ask your practice manager to collect as much as is reasonably available. Some computer software (such as GPASS in Scotland) can generate a practice profile automatically. This is especially useful for comparing practice data with other practices, or for collating data for groups of practices. Several networks exist in different parts of the country to optimise the use of such data.¹³

Stage 2: Collect hospital, community trust, and census data

Standard "routine" hospital utilisation data does not routinely get fed back to practices. Thus the knowledge and understanding that most general practitioners have of the hospital services that their group of patients receive is limited. Although routinely collected clinical data may contain inaccuracies,¹⁴ the quality of some databases has substantially improved.¹⁵ With the help of local public health departments, detailed hospital utilisation can now be compared between practices and localities. Such data must be interpreted carefully, as demand and supply often have more influence on hospital usage than does need. Use of hospital services may not be a proxy for morbidity in the community.¹⁶ The box on the next page lists the variables which general practitioners working in Edinburgh's south east locality found most informative for understanding the current usage of hospital services by individual practices.

Health authorities and boards also have a range of census information, available at small area level. This

information is extremely useful to highlight social inequities at small area level such as in an underprivileged housing estate. Jarman and Townsend scores may be available, but at practice or locality level the six census categories listed in the box may be sufficient to give a view of social need. Unless you request very specific, interesting summary data from the health authority or board you will be swamped with too much detail, which will obscure the larger picture and be too lengthy for general practitioners to absorb.

At practice level such data can be presented at a practice planning meeting and inform the practice's annual business plan. In southeast Edinburgh locality, the above data were fed back at a meeting to which one general practitioner from each practice was invited. Protected time—and hence a good attendance—was gained making a fee from the general practice fundholding management allowance available to all attendees. After the abolition of fundholding, similar exercises should be possible, using the management allowances associated with the new primary care groups. This data highlighted considerable variations in the use of inpatient services, outpatient services, and community services such as nursing and chiropody, with the two most common reasons for admission (termination of pregnancy and dental caries) both preventable. The general practitioners, after presentation of the data and discussion, left written comments about what they found most interesting about their practice, suggestions to improve or extend the data, and how the data could be used by individual practices and the locality. Subsequent meetings are planned to gain other perspectives of need in the locality from other data sources.

Stage 3: Gaining public involvement

Health professionals define “needs” in terms of services that they can provide, whereas patients may have a different perception of what would make them healthier: a job, a bus route to the hospital, or some advice on benefits, for example. Thus interaction and input from patients and the public is vital to gain an “honest consumer perspective.” It can be obtained through:

- Interviews with patients
- Informal discussions with, for example, voluntary groups, community health council
- Suggestion boxes
- Complaints procedures
- Health forum
- Focus groups (with elderly or diabetic patients, for example; see box)
- Rapid appraisal (see box, next page).

Stage 4: Undertake (or use an existing) postal survey

Surveys to assist local decision making must be modestly defined and use a mixture of lay and medical concepts. Computerised search and mail merge facilities allow most practices to send questionnaires (with covering letters and reply paid envelopes) to specific patient groups. A well conducted postal survey of a representative sample can give a reliable estimate of the true burden of morbidity in the population, and may inform contract specification. Assistance will normally be required to select an instrument or to design one, and with sampling and data analysis. Various validated instruments for generic and disease specific surveys are available.²⁰ Questions concerning the areas

Hospital, community trust, and census data

Inpatient data

- Ten most frequent diagnoses made at hospital inpatient discharge (rates per 1000 registered patients), tabulated in descending order. (ICD-10 codes to three digits are recommended; transfers are excluded; patients with multiple discharges from the same hospital, using the same facility and with the same diagnosis, are counted only once.)
- Elective admission (rate per 1000 residents)
- Non-elective admission (rate per 1000 residents)
- Mean waiting time (days)
- Ten most frequent day case diagnoses (per 1000 patients), tabulated in descending order of frequency
- Top three day case procedures (per 1000 patients), in descending order of frequency

Outpatient data

- Outpatient referral rate per 1000 residents
- Referral rates for five most used specialties, tabulated in descending frequency
- Mean waiting time (days)
- Attendances at accident and emergency department (per 1000 patients)

Obstetric data

- Births (rate per 1000 registered patients)

Community data

- District nursing visits (per 1000 patients per year)
- Health visitors, visits, and clinic attendances (per 1000 patients per year)

Investigations

- Use of investigations (per 1000 patients per year) for microbiology, haematology, biochemistry, radiology, electrocardiography

Referrals

- Physiotherapy (per 1000 patients per year, clinic and domiciliary)
- Chiropody (per 1000 patients per year, clinic and domiciliary)
- Occupational therapy (per 1000 patients per year)

Census

- Percentage of residents with limiting long term illness
- Demographic profile, in 5 year bands
- Unemployment rates (%) for men and women
- Percentage of house owners
- Percentage of car owners
- Percentage of households with lone parents

Focus groups¹⁷

- Facilitated discussion groups that allow the members of the target population to express ideas spontaneously
- Can give useful insights into perceived needs, quality of services, and understandings of health issue
- Can raise issues that are important to patients
- Information gained is not quantifiable
- Facilitators need some training
- A variety of groups may be necessary to be representative in some situations

Practical points:

- Optimum size is 8-12 participants
- Facilitator introduces topics for discussion
- Proceedings are recorded using a tape recorder and later transcribed, or notes are taken, preferably by another facilitator

outlined in the box on the next page may be especially relevant, as such data may not be obtained easily from other sources.

Rapid appraisal

A team, ideally with a mixture of professional insights, gathers data about both needs and resources in the area under study from:

- Interviews with key informants (individuals with knowledge of the community) and patients
- Available documents about the neighbourhood or community
- Observations made inside homes and in the neighbourhood

Practical points:

- Use the framework of an information pyramid^{18 19} to guide collection and analysis
- Collate the needs, priorities, and solutions perceived in the community for each box of the information pyramid
- Consider facilitating change in primary care services, commissioning of secondary care, and local advocacy to improve wider determinants of health

Areas for questionnaire surveys

- Acute illnesses and experience of common symptoms
- Use of health services over the past 6 or 12 months
- Patients' satisfaction
- Perceived need for current and potential services
- Specific concerns and worries that may affect health
- Specific questions for people with specific long term health problems or carers
- Chronic illness (may not be necessary if data obtained already):
Any long term illness
Several marker conditions (for example, hypertension, back pain)
- Consider a general health status instrument (SF-36, SF-12)
- Consider a disease specific instrument

(Consider checking a sample of medical records from non-respondents.)

Stage 5: Collation of the information from the different sources

At practice level

Present the major findings of each method to a meeting attended by as many of the practice team as possible, and discuss what changes should be made to the established work patterns and services the practice offers. New initiatives identified should be prioritised and incorporated in the practice's business plan for the coming year. Feedback can be given to the local hospitals and community trusts if relevant.

At locality level (primary care group)

As the stages of the needs assessment may take several months, present the major findings of each method as they become available. Protected time is vital for practice representatives to study the information together; starting to get a feel for the needs of the locality as the complementary data builds up. A specific meeting, possibly facilitated by the local public health department, will be important to prioritise the suggestions raised by the various sorts of data. Techniques for prioritising needs include the nominal group technique, and use of a ranking matrix can give useful structure to such meetings. With the nominal group technique, needs or interventions are listed, discussed, then ranked by each participant until an agreed level of consensus is reached. This encourages debate, and quick decisions can be made. To use a ranking matrix, criteria for priority interventions are defined, such as

potential to improve health, capacity to implement, and equity implications. Participants score each potential intervention for each criterion, and the scores are totalled.²⁰

Health needs assessment is a cyclical process. Needs change over time; evaluating how well needs have been met will bring you back to assessing the needs that have not been met by your action.

How realistic is assessment of health needs in primary care?

Lack of planning time and the pressure to respond to the immediate needs of patients has to date prevented needs assessment in primary care. The fundholding initiative, emphasising efficient purchasing of services, has not championed needs assessment and has largely ignored aspects of health needs not related to the health service. The advent of locality commissioning and the creation of primary care groups will now allow some general practitioners protected time for needs assessment. This strategic work is realistic and possible and has the potential to make primary care more effective at improving health by targeting available resources. But resources, training, and liaison with public health physicians will be necessary for this to work.

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- 1 Secretary of State for Health. *The new NHS*. London: Stationery Office, 1997. (Cm 3807.)
- 2 Secretary of State for Scotland. *Designed to care: renewing the NHS in Scotland*. Edinburgh: Stationery Office, 1997.
- 3 Shanks J, Kheraj S, Fish S. Better ways of assessing health needs in primary care. *BMJ* 1995;308:480-1.
- 4 Lalonde J. *A new perspective on the health of Canadians. A working document*. Ottawa: Information Canada, 1974.
- 5 Murray SA, Graham LJC. Practice based needs assessment: use of four methods in a small neighbourhood. *BMJ* 1995;310:1443-8.
- 6 Williams R. Diabetes mellitus. In: Stevens A, Raftery J, eds. *Health care needs assessment*. Oxford: Radcliffe Medical Press, 1994:31-57.
- 7 Harris A. *Needs to know: a guide to needs assessment for primary care*. London: Churchill Livingstone, 1997.
- 8 Gillam S, Murray SA. Needs assessment in general practice. London: Royal College of General Practitioners, 1996. (Occasional paper 73.)
- 9 Hooper J, Longworth P. *Health needs assessment in primary care. A workbook for primary health care teams*. Wakefield: Calderdale and Kirklees Health Authority, 1997.
- 10 Scottish Needs Assessment Programme. *A rough guide to needs assessment in primary care*. Glasgow: Scottish Needs Assessment Programme, 1997.
- 11 Acton C, Newbronner E. *Health needs assessment. Step by step*. York: University of York, York Economics Consortium, 1998.
- 12 Mays N, Pope C. Observational methods in healthcare settings. *BMJ* 1995;311:182-4.
- 13 Smith N, Wilson A, Weekes T. Use of Read codes in the development of a standard database. *BMJ* 1995;311:313-5.
- 14 Hobbs FDR, Parle JV, Kenkre JE. Accuracy of routinely collected clinical data on acute medical admissions to one hospital. *Br J Gen Pract* 1997;47:439-40.
- 15 Harley K, Jones C. Quality of Scottish morbidity record (SMR) data. *Health Bull* 1996;54:410-7.
- 16 Payne JN, Coy J, Patterson S, Milner PC. Is use of hospital services a proxy for morbidity? A small area comparison of the prevalence of arthritis, depression, dyspepsia, obesity, and respiratory disease with inpatient admission rates for these disorders in England. *J Epidemiol Community Health* 1994;48:74-8.
- 17 Kitzinger J. Introducing focus groups. *BMJ* 1995;311:299-302.
- 18 Murray SA, Tapson J, Turnbull L, McCallum J, Little A. Listening to local voices: adapting rapid appraisal to assess health and social needs in general practice. *BMJ* 1994;308:698-700.
- 19 Annett H, Rifkin SB. *Guidelines for rapid participatory appraisal to assess community health needs: a focus for health improvements for low-income urban and rural areas*. Geneva: World Health Organisation, 1995.
- 20 Wilkin D, Hallam L, Dogget M. *Measures of need and outcomes in primary health care*. Oxford: Oxford Medical, 1992.

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*Economics notes***Perspectives in economic evaluation**

Sarah Byford, James Raftery

Before an economic evaluation begins, the perspective of the study should be determined, as it may have implications for trial design.¹ Since economic evaluations are often used to assess the relative efficiency of alternative healthcare interventions, the perspective commonly taken is that of the health service.² Because of its foundations in welfare economics, however, health economics is concerned with society's welfare. It therefore argues that an economic evaluation should include the impact of an intervention on the welfare of the whole of society, not just on the individuals or organisations directly involved.

Central to economic theory is the question of how to get the most benefit from the scarce resources available to a society. An economic evaluation which confined itself to the NHS's perspective could determine the mix of interventions that would maximise health outcomes within the limited NHS budget. However, this would not necessarily maximise the welfare of society within resources available (gross national product) for two main reasons.

Firstly, sectors other than the health service may incur costs or benefits as a result of healthcare interventions. Consider for example, the reduction of psychiatric hospital beds, which might seem cost effective from the perspective of the health service but less so from that of society as a whole, including patients' or carers' perspectives. A societal perspective helps detect cost shifting between sectors.

Advantages of a societal approach

Secondly, a narrow perspective takes no account of alternative uses for resources outside the healthcare sector, which may yield greater welfare to society. The concept of opportunity cost reflects this broad concern for society's total welfare. Because the total economic output of society is limited, choosing to devote resources to health care necessarily implies forgoing the benefits (or opportunities) of using those resources in an alternative sector, such as education or social services, or indeed not raising them as taxes.

Since the NHS is a universally accessible service, funded by taxation, it can be argued that its decisions should be from the perspective of all those who use it and pay for it—the whole population. Epidemiology and economics share a concern with populations. Adopting a societal or population perspective facilitates policies aimed at maximising the welfare gains to society, or minimising the losses. Excluding particular groups could hinder this process and be less equitable than attempting to include the views of all.

The utilitarianism that underpins welfare economics has been characterised as a poor basis for a personal philosophy (uncaring, calculating, and consequentialist) but an appropriate basis for public policy.³ While a utilitarian, societal perspective can be justified in principle, its practice can be difficult. Ethical dilemmas can arise between individual and societal

perspectives.⁴ When an individual is denied (even possibly ineffective) treatment the lack of a societal consensus can become stark. How individual preferences are to be aggregated to a societal preference remains a theoretical and practical challenge.

To certain organisations, a societal perspective may seem unnecessary. A clinical directorate faced with difficult decisions within a tight budget may take a directorate perspective, in turn requiring the wider organisation to act to prevent cost shifting or other undesirable effects. For-profit organisations, such as pharmaceutical companies, may well take a narrow financial perspective, in turn leading to regulation by the state to safeguard wider concerns. The emphasis in guidelines for pharmacoeconomic evaluations to include a societal perspective, however, is striking.

For policy purposes, study comparability is enhanced by adopting a societal perspective as a norm. A report for the US Public Health Service recommended a societal perspective, for which it saw welfare economics as providing the best theoretical framework, for use in reference case economic evaluations—those that aim to provide results that could be compared throughout the healthcare system.

In practice, it may not always be possible for all the relevant costs and benefits to be included in an economic evaluation because of funding or time constraints. A good case can be made for excluding particular effects if they are likely to have little impact on the overall results. Pretrial literature reviews and modelling can help prioritise items of importance. A "reduced list" method has been shown to capture most relevant costs in mental health service evaluations,⁵ with the five most costly services accounting for 94% of the total cost and the next five for only 4%. Such short cuts require further evaluation before they are more widely applied. A similar analysis on costing screening for colorectal cancer found reduced list costing to be less successful.⁶ As economic evaluation becomes more standardised it may be possible to justify such limited perspectives for costing particular diseases or services.

At the very least economic evaluations should be explicit about the perspective they adopt. The exclusion of items, whether for practical reasons or as a result of pretrial assessments, must be made explicit, explained, and discussed in terms of their likely influence on the final results. Studies with non-societal perspectives may result in suboptimal resource allocation decisions and a corresponding loss in the total welfare of society.

This is the second in a series of occasional notes on economics

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1 Gold MR, Siegel JE, Russell LB, Weinstein MC. *Cost-effectiveness in health and medicine*. New York: Oxford University Press, 1996.

2 Johannesson M. A note on the depreciation of the societal perspective in economic evaluation of health care. *Health Policy* 1995;33:59-66.

3 Goodin RE. *Utilitarianism as a public philosophy*. Cambridge: Cambridge University Press, 1995.

4 Sackett D. *The doctor's (ethical and economic) dilemma*. London: OHE, 1996.

5 Knapp M, Beecham J. Reduced list costings: examination of an informed short cut in mental health research. *Health Economics* 1993;2:313-22.

6 Whynes DK, Walker AR. On approximations in treatment costing. *Health Economics* 1995;4:31-9.